FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024943

Facility Name: Milestone-Elmwood Heights

Address: 2662 Elmwood Road (Number) Rockford (City) 61103 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7001 **Fax #** (815) 654-6445

IDPA ID Number: 362769801

Date of Initial License for Current Owners: 09/01/79

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Hugh Lippitt **Telephone Number:** (815) 654-6100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Hugh W. Lippitt

(Title) Senior Vice President & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	84	Intermediate/DD	84	30,660	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,171			30,171	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,171			30,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.41%

D. How many bed-hold days during this year were paid by the Department?
317 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/04/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	134,716	13,008	1,605	149,329		149,329		149,329			1
2	Food Purchase		269,034		269,034		269,034		269,034			2
3	Housekeeping	140,069	94,594	17,028	251,691		251,691		251,691			3
4	Laundry		34,586		34,586		34,586		34,586			4
5	Heat and Other Utilities			158,013	158,013		158,013		158,013			5
6	Maintenance	159,537	250,508	18,649	428,694		428,694		428,694			6
7	Other (specify):*											7
8	**TOTAL General Services**	434,322	661,730	195,295	1,291,347		1,291,347		1,291,347			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	2,487,934	257,418	71,330	2,816,682		2,816,682		2,816,682			10
10a	Therapy											10a
11	Activities		39,928	80	40,008		40,008		40,008			11
12	Social Services											12
13	CNA Training	173,826			173,826		173,826		173,826			13
14	Program Transportation		21,093	4,274	25,367		25,367		25,367			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,661,760	318,439	90,684	3,070,883		3,070,883		3,070,883			16
	C. General Administration											
17	Administrative	35,465		84,825	120,290	(34,589)	85,701		85,701			17
18	Directors Fees											18
19	Professional Services			29,723	29,723		29,723		29,723			19
20	Dues, Fees, Subscriptions & Promotions			26,216	26,216		26,216		26,216			20
21	Clerical & General Office Expenses	134,436	46,696	22,458	203,590	34,589	238,179		238,179			21
22	Employee Benefits & Payroll Taxes			622,135	622,135		622,135	(810)	621,325			22
23	Inservice Training & Education			1,488	1,488		1,488		1,488			23
24	Travel and Seminar			17,744	17,744		17,744		17,744			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,948	50,948		50,948		50,948			26
27	Other (specify):*											27
28	**TOTAL General Administration**	169,901	46,696	855,537	1,072,134		1,072,134	(810)	1,071,324			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,265,983	1,026,865	1,141,516	5,434,364		5,434,364	(810)	5,433,554			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Milestone-Elmwood Heights #0024943 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			202,247	202,247	5,944	208,191	(103,092)	105,099			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			465	465		465		465			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,330	22,330	(3,986)	18,344		18,344			35
36	Other (specify):* **Alloc. Maint Bldg**			1,958	1,958	(1,958)						36
37	**TOTAL Ownership**			227,000	227,000		227,000	(103,092)	123,908			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			321,744	321,744		321,744		321,744			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			321,744	321,744		321,744		321,744			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,265,983	1,026,865	1,690,260	5,983,108		5,983,108	(103,902)	5,879,206			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,092)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5-A	(810)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (103,902)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (103,902)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Milestone-Elmwood Heights

ID# 0024943

Report Period Beginning: 07/01/04

Ending: 06/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Correct Allocation	$ (810)	22	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(810)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone-Elmwood Heights **#** 0024943 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(810)	0	0	0	0	0	0	0	0	0	0	(810)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(810)	0	0	0	0	0	0	0	0	0	0	(810)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(810)	0	0	0	0	0	0	0	0	0	0	(810)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(103,092)	0	0	0	0	0	0	0	0	0	0	(103,092)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(103,092)	0	0	0	0	0	0	0	0	0	0	(103,092)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(103,902)	0	0	0	0	0	0	0	0	0	0	(103,902)	45

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	See Pages 24 & 25				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 27	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Milestone, Inc.-Central Office
Street Address: 4060 McFarland Road
City / State / Zip Code: Rockford, IL 61111
Phone Number: (815) 654-6100
Fax Number: (815) 654-6444

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Wages	Days	57,670	4	$ 253,395	$ 253,395	30,660	$ 134,716	1
2	1	Dietary Supplies	Days	113,880	31	48,315		30,660	13,008	2
3	2	Food Purchase	Days	113,880	31	999,268		30,660	269,034	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	212,326	212,326	91,980	140,068	4
5	6	Maintenance Wages	Level of Care/Days	276,670	31	479,877	479,877	91,980	159,537	5
6	17	Administrative-Other	Level of Care/Days	8,834,400	36	339,464		2,207,520	84,825	6
7	21	Clerical Wages	Level of Care/Days	8,834,400	36	294,721	294,721	2,207,520	73,644	7
8	21	Office Supplies	Level of Care/Days	8,834,400	36	186,877		2,207,520	46,696	8
9	21	Telephone	Level of Care/Days	8,834,400	36	89,876		2,207,520	22,458	9
10	22	Fringe Benefits	Wages	14,184,642	37	2,698,504		3,265,983	621,325	10
11	35	Rent-Computer	Level of Care/Days	8,834,400	36	15,953		2,207,520	3,986	11
12	36	Rent Maintenance Building	Level of Care/Days	8,834,400	36	7,837		2,207,520	1,958	12
13										13
14										14
15										15
16		See Addendum A								16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,626,413	$ 1,240,319		$ 1,571,255	25

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Amcore Bank N.A.,Rockford		X	2002 Ford Van	$761.50	8/17/01	$ 24,647	$	08/20/04	7.0000	$ 48	1
2	Amcore Bank N.A.,Rockford		X	2002 Ford Van	$762.00	8/29/01	24,647		09/05/04	7.0000	(190)	2
3												3
4												4
5												5
	Working Capital											
6	Amcore Bank N.A.,Rockford		X	Line of Credit	N/A	7/23/01	5,000,000		01/10/06	6.0000	607	6
7												7
8												8
9	TOTAL Facility Related				$1,523.50		$ 5,049,294	$			$ 465	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,049,294	$			$ 465	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Milestone-Elmwood Heights **#** 0024943 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002		10
2003		11
2004		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Milestone-Elmwood Heights COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0024943

CONTACT PERSON REGARDING THIS REPORT Hugh W. Lippitt

TELEPHONE (815) 654-6100 FAX #: (815) 654-6444

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,570 B. General Construction Type: Exterior Brick Frame Cement Block Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Project	261,356	1978	$ 105,000	1
2	Recreational Land	588,087	1978		2
3	TOTALS	849,443		$ 105,000	3

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1980	1979	$ n/a	$ 94,122	30	$	$ (94,122)	$ n/a	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Kitchen Design Plan			1978	550		5			550	9
10	Intercom System			1978	12,716		10			12,716	10
11	Door Locking System			1978	14,081		10			14,081	11
12	Floor Tile			1979	2,870		10			2,870	12
13	Landscaping			1980	25,659		5			25,659	13
14	Sign			1980	725		5			725	14
15	Chain Link Fence			1980	1,377		5			1,377	15
16	Landscaping			1980	4,071		5			4,071	16
17	Storage Building			1980	8,471		5			8,471	17
18	Landscaping			1981	595		5			595	18
19	Bike Path, Parking Lot, Basketball Court			1982	22,944		15			22,944	19
20	Parking Lot Repairs			1982	2,216		15			2,216	20
21	Room Remodeling			1983	4,312		10			4,312	21
22	Concrete Slab for Shelter			1984	6,751		15			6,751	22
23	Park Shelter			1984	13,058		15			13,058	23
24	Driveway Maintenance			1984	2,201		5			2,201	24
25	Sewer Repair			1984	1,195	25	20	25		1,195	25
26	Landscaping-Trees			1985	1,677		5			1,677	26
27	Landscaping-Plantscape			1986	4,117		10			4,117	27
28	Sidewalk Concrete			1988	2,930	146	20	146		2,440	28
29	Sidewalk Improvements			1990	5,490	274	20	274		4,187	29
30	Parking Lot			1990	3,097	91	15	91		3,097	30
31	Parking Lot Repairs			1991	2,430	162	15	162		2,268	31
32	Roof			1992	3,969	198	20	198		2,604	32
33	Outdoor Drinking Fountain			1992	1,998	100	20	100		1,308	33
34	Telephone System			1992	9,600	66	12	66		9,600	34
35	Roof Repairs			1993	6,965	348	20	348		4,092	35
36	Sump Pumps			1993	4,721		10			4,721	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Furnace	1994	$ 40,882	$ 2,044	20	$ 2,044	$	$ 21,812	37
38	Telephones	1994	3,111	259	12	259		2,788	38
39	Air Handler	1995	1,668		7			1,668	39
40	Above Ground Tank	1995	4,825	241	20	241		2,433	40
41	Concrete	1995	5,575	279	20	279		2,761	41
42	Furnace	1995	9,618	481	20	481		4,742	42
43	Roof	1995	1,290	64	20	64		629	43
44	Kitchen Sink	1995	1,300	65	20	65		629	44
45	Road Stone	1996	1,120		5			1,120	45
46	Air Conditioner	1996	2,476	124	20	124		1,084	46
47	Tile	1996	360		5			360	47
48	Sinks	1997	6,470	431	15	431		3,558	48
49	Flood Lights	1997	2,550	128	20	128		1,031	49
50	Air Conditioner	1997	4,055	203	20	203		1,639	50
51	Sidewalk	1997	6,691	335	20	335		2,676	51
52	Black Top Parking Lot	1997	85,125	5,675	15	5,675		45,400	52
53	Smoke Detectors	1997	16,100	1,073	15	1,073		8,407	53
54	Roof	1997	7,070	353	20	353		2,740	54
55	Counters	1997	3,706	247	15	247		1,874	55
56	Fire Alarm System	1998	3,660	183	20	183		1,357	56
57	Acoustical Ceiling	1998	1,650	83	20	83		612	57
58	Sidewalk Repair	1998	5,660	283	20	283		1,981	58
59	Duct Work	1998	1,017	51	20	51		356	59
60	Tile Repair	1998	650		5			650	60
61	Air Conditioner	1998	2,742	183	15	183		1,279	61
62	Carpet	1998	1,544	221	7	221		1,526	62
63	Driveway Repairs	1998	2,372	158	15	158		1,081	63
64	Roof	1998	2,000	100	20	100		675	64
65	Dry Valve	1998	1,540	154	10	154		1,039	65
66	Roof	1999	5,970	298	20	298		1,941	66
67	Dry Valve	1999	1,815	182	10	182		1,059	67
68	Tile	1999	2,600	217	5	217		2,600	68
69	Acoustical Ceiling	2000	6,750	337	20	337		1,713	69
70	TOTAL (lines 4 thru 69)		$ 414,748	$ 109,984		$ 15,862	$ (94,122)	$ 289,123	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 414,748	$ 109,984		$ 15,862	$ (94,122)	$ 289,123	1
2	Carpet	2000	12,538	2,508	5	2,508		12,057	2
3	Counter Tops	2000	1,622	108	15	108		505	3
4	Automatic Doors	2002	4,148	830	5	830		2,903	4
5	Tile	2002	2,760	552	5	552		1,886	5
6	Water Heater	2002	4,200	420	10	420		1,435	6
7	Water Heater	2002	8,135	1,627	5	1,627		5,216	7
8	Carpet	2002	2,232	446	5	446		1,303	8
9	Tile	2002	2,160	432	5	432		2,160	9
10	Cabinets	2003	2,449	163	15	163		340	10
11	Sump Pump	2003	7,218	722	10	722		1,504	11
12	Carpet	2003	8,950	1,790	5	1,790		3,580	12
13	Air Conditioner	2003	4,705	470	10	470		941	13
14	Carpet	2003	5,309	1,062	5	1,062		2,124	14
15	Cabinets	2003	2,409	161	15	161		308	15
16	Water Heater	2003	3,695	739	5	739		1,293	16
17	Acoustical Ceilings	2004	11,040	552	15	552		828	17
18	Carpet	2004	2,094	299	7	299		449	18
19	Remove ceiling tile & install drywall ceilings	2004	20,380	1,359	15	1,359		1,925	19
20	Carpet	2004	5,058	723	7	723		903	20
21	Thermastatic control system for heat and air	2004	29,322	1,466	20	1,466		1,833	21
22	Heater	2004	4,660	466	10	466		544	22
23	Cabinets	2004	8,204	547	15	547		592	23
24	Carpet	2004	27,534	3,039	7	3,039		3,039	24
25	Smoke & Heat Detectors	2004	6,945	579	10	579		579	25
26	Vinyl Floor	2004	7,242	776	7	776		776	26
27	Vinyl Floor	2005	5,102	364	7	364		364	27
28	Cabinets	2005	20,031	378	15	378		378	28
29	Counter Tops	2005	3,097	86	15	86		86	29
30	Ceramic Tile	2005	3,377	121	7	121		121	30
31	Water Pipe Repair	2005	8,955		25				31
32	Capital Grant Building			970			(970)		32
33	Allocated Maintenance Building			1,958		1,958			33
34	TOTAL (lines 1 thru 33)		$ 650,319	$ 135,697		$ 40,605	$ (95,092)	$ 339,095	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 350,453	$ 38,302	$ 38,302	$	5-15 yrs	$ 231,566	71
72	Current Year Purchases	37,186	5,275	5,275		7-15 yrs	5,275	72
73	Fully Depreciated Assets	407,679					407,679	73
74	Allocated Computer System	N/A	3,986	3,986				74
75	TOTALS	$ 795,318	$ 47,563	$ 47,563	$		$ 644,520	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Page 30			$ 344,845	$ 24,931	$ 16,931	$ (8,000)		$ 281,418	76
77										77
78										78
79										79
80	TOTALS			$ 344,845	$ 24,931	$ 16,931	$ (8,000)		$ 281,418	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,895,482	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,191	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 105,099	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (103,092)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,265,033	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 9,864 Description: Copier
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Program	2005 Buick Park Avenue	$ 720.00	$ 8,480	17
18					18
19					19
20					20
21	TOTAL		$ 720.00	$ 8,480	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	17,222	29,880		47,102
4	Clinical Wages	(b)	42,854	59,760		102,614
5	In-House Trainer Wages	(c)	9,675	14,435		24,110
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$ 69,751	$ 104,075	$	$ 173,826
10	SUM OF line 9, col. 1 and 2	(e)	$ 173,826			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	83
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	89
2. From other facilities (f)	
TOTAL TRAINED	172

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Milestone-Elmwood Heights **#** 0024943 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,400	$ 436,023	1
2	Cash-Patient Deposits	26,507	123,060	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	849,472	3,353,405	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,554	6
7	Other Prepaid Expenses	2,433	68,303	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other A/R		16,783	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 880,812	$ 4,003,128	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	151,429	1,387,045	13
14	Buildings, at Historical Cost	3,488,531	16,594,819	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,515,008	5,304,025	16
17	Accumulated Depreciation (book methods)	(4,001,334)	(12,076,469)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	81,448	115,573	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(81,448)	(114,004)	20
21	Restricted Funds		1,190,500	21
22	Other Long-Term Assets (spe Escrow & loan fees		710,215	22
23	Other(specify): Value Life Ins&Const. In Prog		283,996	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,153,634	$ 13,395,700	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,034,446	$ 17,398,828	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 351,127	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,507	123,060	28
29	Short-Term Notes Payable		350,000	29
30	Accrued Salaries Payable		855,096	30
31	Accrued Taxes Payable (excluding real estate taxes)		191,016	31
32	Accrued Real Estate Taxes(Sch.IX-B)		69	32
33	Accrued Interest Payable		108,977	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Pension,Wrkmns Comp,Sec Dep,etc		568,539	36
37	Intercompany A/P	3,007,097		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,033,604	$ 2,547,884	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,855,808	40
41	Bonds Payable		3,470,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,325,808	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,033,604	$ 8,873,692	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (999,158)	$ 8,525,136	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,034,446	$ 17,398,828	48

***(See instructions.)**

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (375,831)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (375,831)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(623,327)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (623,327)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (999,158)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,270,599	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,270,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	81,122	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 81,122	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Provided Information	60	28
28a	Gain on Sale of Vehicles	8,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,060	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,359,781	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,291,347	31
32	Health Care	3,070,883	32
33	General Administration	1,072,134	33
	B. Capital Expense		
34	Ownership	227,000	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	321,744	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,983,108	40
41	**Income before Income Taxes (line 30 minus line 40)****	(623,327)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (623,327)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.** **See Page 28**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,808	2,090	$ 50,335	$ 24.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,608	1,716	36,153	21.07	3
4	Licensed Practical Nurses	15,176	16,935	314,361	18.56	4
5	CNAs & Orderlies					5
6	CNA Trainees	18,715	18,715	173,826	9.29	6
7	Licensed Therapist	410	410	27,131	66.17	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	610	689	17,268	25.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,076	11,253	117,448	10.44	15
16	Dishwashers					16
17	Maintenance Workers	10,325	11,925	159,537	13.38	17
18	Housekeepers	13,505	15,264	140,069	9.18	18
19	Laundry					19
20	Administrator	1,057	1,206	35,465	29.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,929	4,388	73,644	16.78	23
24	Clerical	5,460	6,010	60,792	10.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	20,329	23,328	362,851	15.55	28
29	Resident Services Coordinator	288	320	5,438	16.99	29
30	Habilitation Aides (DD Homes)	148,229	162,438	1,691,665	10.41	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	251,525	276,687	$ 3,265,983 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	54	$ 1,605	1-3	35
36	Medical Director	120	15,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	2,100	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	245	12,264	10-3	46
47	Psychologist/Psychiatrist	575	56,430	10-3	47
48	Religious/Education	4	80	11-3	48
49	TOTAL (lines 35 - 48)	1,058	$ 87,479		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17	$ 536	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	17	$ 536		53

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Thornbloom	Administrator	0	$ 35,465
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 35,465

B. Administrative - Other

Description	Amount
Administrator	$ 28,073
Assistant Administrator	22,163
Accountant	25,438
Secretary	9,151
TOTAL (agree to Schedule V, line 17, col. 3)	$ 84,825
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Brechon,Knuckles & Ryan	Administrative Consultant	$ 5,148
Various	Computer/programming	2,037
Various	Legal Fees	17,333
Lindgren,Callihan & VanOsdol	Audit	5,205
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,723

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,278
Unemployment Compensation Insurance	11,194
FICA Taxes	239,830
Employee Health Insurance	219,662
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	57,562
Employee Physical Exams	2,048
Applicant Referral Expense	1,358
Other Employee Benefits	11,393
TOTAL (agree to Schedule V, line 22, col.8)	$ 621,325

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,107
Health Care Worker Background Check	
(Indicate # of checks performed 107)	2,140
Fees	1,619
Dues	47
Books & Periodicals	2,303
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,216

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
See Page 26	17,744
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,744

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **321,744**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No-See Page 29**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Lindgren, Callihan, VanOsdol Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.